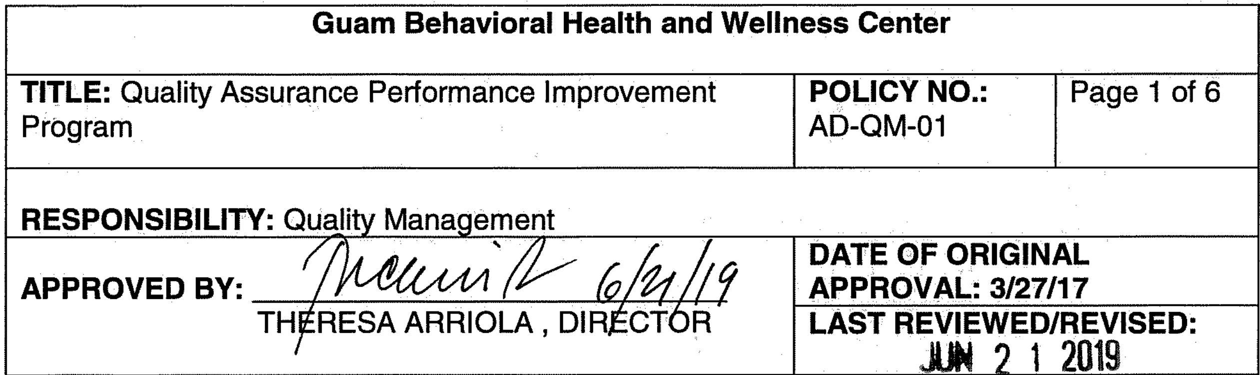

Guam Behavioral Health and Wellness Center		
TITLE: Quality Assurance Performance Improvement Program	**POLICY NO.:** AD-QM-01	Page 1 of 6
RESPONSIBILITY: Quality Management		
APPROVED BY: [signature] 6/21/19 THERESA ARRIOLA , DIRECTOR	**DATE OF ORIGINAL APPROVAL: 3/27/17**	
	LAST REVIEWED/REVISED: JUN 2 1 2019	

PURPOSE:

A. To provide a Quality Assurance Performance Improvement (QAPI) program for the Guam Behavioral Health and Wellness Center (GBHWC) that supports its vision, mission, and organizational priorities.

POLICY STATEMENT:

A. The leadership and management of GBHWC support an environment that encourages the identification of improvement opportunities from all sources throughout the organization and the provision of care and services that are reflective of the organization's mission and vision (*see Mission, Vision and Core Value Policy AD-23).*

B. GBHWC shall have a quality assurance improvement program that provides a systematic, coordinated, continuous monitoring, collecting and analyzing data driven approach to improving performance focusing on processes and mechanisms of services that are provided in a safe, effective, consumer centered, timely, equitable and recovery oriented fashion.

C. GBHWC's Quality Management program is based on the principles of Continuous Quality Improvement (CQI). It demonstrates its commitment to continuous quality improvement, through accreditation by Commission on Accreditation of Rehabilitation Services (CARF).

RESPONSIBLITIES

A. <u>Director/Deputy Director</u>
   1. Shall support and guide implementation of quality improvement activities at GBHWC.
   2. Shall review, and approve the Quality Improvement Plan annually.
   3. Shall review reported QI data of all clinical programs, health and safety, risk management as well as business function data such as but not limited to financial reports, human resources and technology report.
   4. Shall approve and prioritize performance improvement initiatives, system and process redesign or change as recommended by QAPI Committee to improve quality of care and consumer satisfaction.
   5. Provide oversight and leadership for all activities relative to GBHWC's Performance Improvement Plan.

A. <u>The QAPI Committee</u>
The Quality Assurance Performance Improvement Committee (QAPIC) shall develop the Quality Improvement Plan and provide ongoing operational leadership of continuous quality improvement activities.
1. It shall be chaired by the designated Quality Improvement Coordinator
2. The membership of the QI Committee shall be as follows
    a. Deputy Director
    b. Designated Psychologist
    c. Risk Management Officer designee
    d. CASD Administrator
    e. Nurse Administrator
    f. Supervisors/Section Heads (Adult Counseling, Community Support Services, Residential Treatment Program, Drug & Alcohol, Healing Hearts, Prevention & Training, Project Tulaika)
    g. Medical Director

3. It shall meet at least monthly to report and review quarterly data gathered from each department.

4. It shall review the Quality Improvement Plan annually and establish measurable objectives based upon priorities identified through the use of establish criteria for improving the quality and safety of clinical services.

5. It shall support improved consumer outcomes by identifying education and training opportunities for personnel and targeting areas in which improvement is needed by reviewing results, performance indicators, consumer feedback.

6. The responsibilities of the committee shall include but not limited to;
    a. Provide direction to the Program Heads on their Performance Improvement measures.

    b. Shall choose indicators, prioritize measures that include high risk and problem prone areas identified throughout the organization, which are trended and analyzed by departments.

    c. Periodically assess information based on the indicators, taking action as evidenced through quality improvement initiatives to solve problems and pursue opportunities to improve quality.

    d. Formally adopting a specific approach to Continuous Quality Improvement e.g. Plan-Do-Study-Act (PDSA), and Lean Enterprise method as deemed appropriate.

B. <u>Quality Improvement Coordinator</u>
The Quality Improvement Coordinator (QIC) shall guide the construction of performance measures, coordinate and monitor the performance indicator and the implementation of the quality improvement programs relating to patient care and support services. The responsibilities shall include but not limited to;

1. Develops and monitor the implementation of quality improvement program.

2. Coordinates program activities with the clinical staff, program or departmental heads.
3. Provide project management, data analysis and measurement of outcomes, document and report the results and accomplishments of quality assurance improvement initiatives to the QAPI committee.
4. Evaluates the effectiveness of agency/departmental quality improvement programs and makes recommendations to identified problems.
5. Coordinates and participates in the quality improvement monitoring activities through chart review, gathering, and collecting data.
6. Gathers compiles and analyzes data from different program and prepare report for presentation to the QAPI committee for review and approval.
7. Conducts educational programs related to quality improvement methodologies and activities as required.
8. Monitors departmental compliance to established quality improvement policies and procedures and reporting calendar.
9. Maintains data records and prepare quarterly and annual trending reports.
10. Analyze Performance Measure annually and reports to the QI Committee and Executive Management Council.

<u>The QAPI Program</u>

A. The QAPI Program shall objectively and systematically monitor and evaluate the quality of care, the services provided to the consumer by assessing care delivery, its effectiveness and efficiency of service, consumer safety, and customer satisfaction.

1. Performance Measures, Data Collection and Analysis
    a. The organization shall choose indicators and data elements that measure high risk and problem prone areas identified throughout the organization.

    b. Data shall be collected on key systems, processes and clinical outcomes to monitor effectiveness, efficiency of service, access to care and consumer satisfaction in accordance with Commission on Accreditation for Rehabilitation Facilities (CARF) standards.

    c. Data collected shall be trended over time to display any variations, improvements and analyze annually so that GBHWC leadership can make informed assumptions and generalizations about what has happened, why this might vary from what was expected, and what corrective action might be required.

2. Data Collection
   Data collection shall be done concurrently and on a monthly basis. The methods in which data will be collected shall be determined by the departments and stated in Performance Improvement plans, with guidance from QI Coordinator and the QPI Committee.

    a. The organization shall take steps to ensure that data are reliable; by training new and existing personnel on recording each data element they are responsible for collecting.
    b. Indicators are explained and periodically reviewed.

i. Indicators are defined with detail, data elements and the type of numerical value to be used to express the indicator e.g. percentage, rate, number of occurrence etc.
ii. Data collection shall be described; how the data will be collected as well as method and frequency of collection, and who will collect the data.

c. The organization shall take steps to ensure that data used for decision making are complete. Database is checked for completeness of records before final analyses are run and decisions made.

d. Collected data shall be submitted to the Quality Improvement Coordinator every 10th of the month.

3. Guidance for continuing or discontinuing monitoring
   a. Standards based measures or mandated indicators from regulatory bodies (e.g. CARF) shall continually be monitored, reflected on one's PI plan, trended, analyzed and reported.

   b. Monitoring activities can be decreased or eliminated for other PI indicators that sustained 95% compliance for a period of 6 consecutive months.

      i. Reporting of this data to QPIC can be discontinued after informing the QPIC; reporting will ensue as needed when significant concerns surface or negative trends arise.
      ii. Monitoring activities can be decreased in frequency from monthly to quarterly and reduced to random spot audits. If compliance is sustained, the measure or indicator may be dropped from monitoring activities and the PI plan must be updated accordingly.

4. Priorities for Monitoring- Standards Related Indicators
   a. In accordance with CARF performance measurement and management standard, the following indicators shall be monitored and analyzed.
      i. Services delivery performance indicators for each program area such as effectiveness of service, efficiency of service, service access satisfaction and other feedback from persons served and stakeholder.
      ii. The organization collects data about the consumer at the beginning of services, appropriate intervals during services, at the end of services and points in time following the services.
   b. The data collected shall address the needs of the persons served, the needs of the other stakeholders and the business needs of the organization. The data collected by the organization shall also include but not limited to;
      i. Financial information,
      ii. accessibility status reports,
      iii. risk management,
      iv. human resources activities,
      v. technology,

vi. health and safety reports,
vii. satisfaction surveys

c. The data collected are used to set written business function and written service delivery, objectives, performance indicators and performance targets.

5. Reports
   a. Annual narrative reports:
   Narrative reports from department will primarily focus on the PI indicator that did not meet goals. These reports shall be submitted to the QI Coordinator every second (2nd) Friday of January prior to the January QPI Committee meeting. (*See attachment I for performance improvement report).*

   b. Trending Sheets
   Trending sheets reflect the performance of all measures/indicators being monitored by departments (based on their PI Plans) over the course of the calendar year. Trending graphs shall be included in the annual analysis report.

   c. Action Plans
   Action Plans should accompany the trending sheets and annual narrative reports when measures/Indicators do not meet expected target goals. The format of action plans may vary, but the following components must be included (*See Attachment II).*
   i. WHAT – describe the improvement actions undertaken
   ii. WHEN – indicate the dates of when the actions will be completed
   iii. WHO – identify those responsible for completing the actions

6. Performance Improvement Model
An interdisciplinary, continuous, performance improvement approach is recognized across GBHWC organization continuum of care and service areas utilizing **FOCUS PDSA model.**

   a. **FOCUS** is defined as:
   i. **FIND** a process that needs improvement
   ii. **ORGANIZE** a team that knows the process
   iii. **CLARIFY** the current knowledge of the process
   iv. **UNDERSTAND** the process and learn the causes of variation
   v. **SELECT** a strategy for continued improvement; start the PDCA cycle

   b. **PDSA** cycle is defined as:
   i. **PLAN -** is based on the result of data collection or the assessment process. The plan should include how the process will be improved and what will be measured to

evaluate the effectiveness of the proposed process change.

ii. **DO** - includes the implementation of the process changes. These changes may be tested before changing policies and procedures or conducting extensive education.

iii. **STUDY-** evaluates the effect of the action taken at a given point in time

iv. **ACT-** is to maintain and hold the gain and to continue to improve and implement the process

7. Performance Improvement Plans
   Performance Improvement Plan is a list of all measures/indicators that department choose to monitor over the course of the calendar year. Format for PI plan shall follow the Performance Plan template (*see Attachment III)*
   a. It shall undergo review and approval by the Performance Improvement Committee
   b. Evaluated PI plans and newly created PI plan shall be submitted to the appropriate Division Heads, prior to year-end, at a date specified by QIC,
   c. All PI Plans shall be collected by the Quality Improvement Coordinator

C. <u>Communication Information Pathway</u>
   1. QAPI activities are communicated through the established QAPI Information Pathway (*See attachment IV Data Reporting Flow Chart)*

DEFINITIONS:

1. <u>Performance Measure:</u> The process of regularly assessing the results produced by the program. It involves identifying processes, systems and outcomes that are integral to the performance delivery system, selecting indicators of these processes, systems and outcomes, and analyzing information related to these indicators on a regular basis.
2. <u>Performance Indicator:</u> A quantitative tool that provides information about the performance of a clinic's or program's process, services, functions or outcomes.

REFERENCES:

CARF. (2019). Behavioral Health Standards Manual. Tucson, Arizona: CARF International.

White, S. V. (2012). Quality and Performance Improvement Q Solutions. Glendale Illinois: National Association for Healthcare Quality.

ATTACHMENTS:

I. *Performance Improvement Annual Report*
II. *Performance Improvement Action Plan*
III. *Performance Improvement Plan Template*
IV. *Data Reporting Flow Chart*
V. *2019 GBHWC Performance Improvement Plan*

GUAM BEHAVIORAL HEALTH & WELLNESS CENTER
790 Gov. Carlos G. Camacho Rd. Tamuning, Guam 96913
TEL: (671) 647-5330 FAX: (671) 649-6948

REVIEW AND ENDORSEMENT CERTIFICATION

The signatories on this document acknowledge that they have reviewed and approved the following:

Policy Title: Quality Assurance Performance Improvement Program
Policy No: AD-QM-01
Initiated by: Cydsel Toledo

Date	Signature
6/3/19	[signature]
Cydsel Toledo Quality Improvement Coordinator	
Date	**Signature**
6/3/2019	[signature]
Debbie Paulino Administrative Officer	
Date	**Signature**
6/13/2019	[signature]
Maelei Sampson Human Resources	
Date	**Signature**
6/4/2019	[signature]
Alfred Garrido Health & Safety Officer	
Date	**Signature**
7/9/2019	[signature]
Joseph Baza Computer System Analyst II	
Date	**Signature**
06/5/2019	[signature]
Dr. Ariel Ismael Medical Director	
Date	**Signature**
6.5.19	[signature]
Dr. Mary Fegurgur Psychologist	
Date	**Signature**
6/3/2019	[signature]
Reina Sanchez Clinical Administrator	
~~Date~~	~~Signature~~

GUAM BEHAVIORAL HEALTH & WELLNESS CENTER
790 Gov. Carlos G. Camacho Rd. Tamuning, Guam 96913
TEL: (671) 647-5330 FAX: (671) 649-6948

6.3.19	[signature]
Annie Unpingco CASD Administrator	
Date	**Signature**
6/19/19	[signature]
Jeremy Lloyd-Taitano, RN Acting Nurse Administrator	
Date	**Signature**
6/3/19	[signature]
Shermalin Pineda Program Manager-RRP	
Date	**Signature**
06/19/2019	[signature]
Maria Theresa Aguon Program Manager-Healing Hearts	
Date	**Signature**
6/7/19	[signature]
Helen Onedera Project Director-Project Tulaika	
Date	**Signature**
	[signature]
for Linda Flynn Program Coordinator IV, Prevention & Training Supervisor	
Date	**Signature**
6/3/19	[signature]
Athena Duenas Drug & Alcohol Program Supervisor	
Date	**Signature**
6/3/19	[signature]
Sylvia Quinata Adult Counseling Supervisor	
Date	**Signature**
6/19/19	[signature]
Marilyn Miral Community Support Services Supervisor	
Date	**Signature**
7/1/19	[signature]
Carissa Pangelinan Deputy Director	